Division of Health Service Regulation						
AMERICATION MINUSES.		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
		HAL065035	B. WING		08/17/2016	
NAME OF 6	ROVIDER OR SUPPLIER	STREET AD	DRESS, OITY, S	ITATE, ZIP CODE		
CEDAR	COVE ASSISTED LIVI	NG	MINE COVE TON, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SO IDENTIFYING INFORMATION)	ID FREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
C 000	Initial Comments	,	C 000			
	Report of Biennial (Harrell on 8/17/201	Construction Survey by Dennis 6.				
	7-28-1994. The fac residents. Therefor to meet the 1991 rt Disabled (Minimum and the applicable Adult Care Homes	ils facility was first licensed on illty is currently licensed for 64 e, we are requiring this facility uses Homes For The Aged and Standards and Regulations) portions of the 2005 Rules for of Seven or More Beds, and tolina State Building Code tional Unrestrained				
C 101	Existing Licensed F	ac- No less than '71 Rules	C 101			
	PHYSICAL PLANT The physical plant care home shall be (2) Except where of licensed facilities of facilities shall meet requirements in eff change in service of renovation, or alter the requirements for no addition or reno than those requirer "Minimum and Des Regulations" for "H	O1 APPLICATION OF REQUIREMENTS requirements for each adult applied as follows: otherwise specified, existing reportions of existing licensed iticensure and code ect at the time of construction, or bed count, addition, ation; however in no case shall or any licensed facility where vation has been made, be less ments found in the 1971 lired Standards and lomes for the Aged and Infirm", a available at the Division of				
Division of	 Based on obser installed Special (n 	et as evidenced by: rvation, the facility recently nagnetic) Locking on the 3			<u> </u>	
LABORATOR	V profession PROV	DEMORTIOPLIER REPORTSENTATIVE'S SIG	A	/ L. 7 th	(XII) DATE	
STATE POR	M. Sight	-	1001	F9PN21	10-3-16 If continuation sheet 1 of	

Division of Health Service Regulation PORM APPROV						APPROVED
STATEMEN	OF CORRECTION	(X1) PROVIDER/BUPPLIER/ČLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
HAL065035			B. WING		08/17/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADS	DRESS, CITY, S	STATE, ZIP GODE		,
GEDAR (COVE ASSISTED LIVI		MINE COVE TON, NO 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) GROSS-REFERENCED TO THE APPRO- DEFICIENCY)	DBE	(XII) COMPLETE DATE
C 101	Continued From pa	ge 1	C 101			
	interview with the fathe installer, Delayer previously provided Egress failed about and was "repaired." the function of the especial (magnetic). The alteration from Locking was done vapproval of the local PDHSR Construction Section 407.11.4 or Code. Note; A Plan of Protine facility agreed to Delayed Egress. It future, the locking is	Delayed Egress to Special without the knowledge or a Building Inspection in Marshal's office and the Section as required by the 2012 NC State Building section was accepted in which a change the locking back to further stated that if, in the set of the changed to Special cumentation will be submitted		On August 18, the Special Co Unit doors were modified to return to delayed agress.	are ,	
	Locking that had be comply with Section 407.11.3.4 and Sec NC State Building C Findings include: a. There was no with component location adjacent to the fire in the fire in the second provided in any hours. b. There was no errorided within 3 fe Note; A Plan of Provide the facility agreed to	ring diagram and systems map provided under glass		NIA		,

Division	of Health Service Re	gulation			FORMA	PEROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
HAL066035		B. WING		08/17/2016		
NAME OF I	ROVIDER OR SUPPLIER	STREET ADS	DRESS, CITY, S	BTATE, ZIP GODE	00/11	,2010_
CEDAR	COVE ASSISTED LIVI	NU	MINE COVE TON, NC 28			
(264) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REPERENCED TO THE APPRO DEFICIENCY)	D 8E	(X5) COMPLETE DATE
C 101	Continued From pa	ge 2	C 101			
		s to be changed to Special cumentation will be submitted oval.				
	to be returned to Do on observation, the with Section 1008.1 Building Code. Sec sign on each locked	ew, the Special Locking was elayed Egress Locking. Based exit doors will fail to comply .9.7.5 of the 2012 NC State tion 1008.1.9.7.5 requires a f door that reads "PUSH JNDS, DOOR CAN BE CONDS."		On August 18, a sign was p at each door in the Special Unit to meet the requirem of Section 1008.1.9.7.5.	Care	
C 140	Linen Storage-Sepa	arate Clean & Soiled	C 140			
	closets are: (2) Linen Storage. adequate in size an storage of clean line soiled linens. Acce be from a corridor of	ts for storage rooms and Storage areas shall be d number for separate ans and separate storage of ss to solled linen storage shall or laundry room;				
	in front of the door t rendered the door t	et as evidenced by: on, items stored in the corridor to the clean linen room unusable. The result was the be carried through the soiled		The items blocking the corri were removed to designate storage areas. The door is r operable.	d i	
C 166	Housekeeping-Mair	ntained Free of Hazards	C 166			
	FURNISHINGS (a) Adult care home	08 HOUSEKEEPING AND		,		
Divizion of H	ealth Service Regulation				_	

NAME OF PROVIDER OR SUPPLIER CEDAR COVE ASSISTED LIVING STREET ADDRESS, CITY, STATE, ZIP CODE 4200 JASMINE COVE WAY WILMINGTON, NC 28412 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	ON TO BE	//2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4200 JASMINE COVE WAY WILMINGTON, NO. 28412	ON TO BE	/2016_
CEDAR COVE ASSISTED LIVING 4200 JASMINE COVE WAY WILMINGTON, NO. 28412	D BE	
WILMINGTON, NO. 28412	D BE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	D BE	1
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG REGULATORY OR LSG IDENTIFYING INFORMATION) TAG REGULATORY OR LSG IDENTIFYING INFORMATION) DEFICIENCY	OULD BE COMPLETE	
C 166 Continued From page 3 C 166		
 (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; (e) This Rule shall apply to new and existing facilities. 		
This Rule is not met as evidenced by: 1. Based on observation, the Special Care courtyard is in a required exit path. The courtyard is not large enough to provide a safe refuge in a fire and the courtyard gate is padiocked closed. Based on interview, most staff did not carry a key to the lock. Note; A Plan of Protection was accepted which stated all staff responsible for evacuation of the residents in an emergency will carry a key to the gate at all times while on duty.	Jnit	
2. Based on observation, the building was not maintained in a safe manner by not properly handling portable medical oxygen cylinders. This could affect all residents, staff and visitors if cylinders fall, breaking their valves, propelling the cylinder and turning it into a dangerous projectile. Findings include: a. Several portable medical oxygen cylinders were stored in bedroom 110 in an unapproved beverage crates. b. Several portable medical oxygen cylinders were stored in bedroom 217 in unapproved beverage crates and in no container at all.	red	
3. Based on observation, the exit corridor near the TV room and Dining room was obstructed with a floor buffer and 4 wheel chairs to only about 3.5 feet of clear width. At least 6 feet of clear width must be maintained in corridors at all times. Floor buffer and wheel chairs have been removed from the corridor.		
Based on observation, the exit corridor by the Olyision of Health Service Regulation		

PRINTED: 09/14/2016 FORM APPROVED

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 01 COMPLETED B. WING. HAL065035 08/17/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4200 JASMINE COVE WAY CEDAR COVE ASSISTED LIVING WILMINGTON, NC 28412 SUMMARY STATEMENT OF DEFICIENCIES (344) 10 PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX COMPLETE TAG REGULATORY OR LISC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY C 166 Continued From page 4 C 166 Mattresses and boxes have laundry was obstructed with 7 mattresses, 25 been removed from the boxes of diapers and 3 large cardboard boxes corridor. containing PTAC units. Corridors must not be used as storage apaces. Based on a review of documents, the fire Procedure has been adopted to extinguishers are not being inspected monthly as document the monthly regulred. Fire extinguishers that are not inspected may fail to operate properly in a fire. inspection of fire extinguishers. 6. Based on a review of documents, the range hood fire suppression system is not being Procedure has been adopted to inspected monthly as required. Fire suppression document the monthly systems that are not inspected may fail to operate inspection of the range hood properly in a fire. fire suppression systems. C 185 Fire Safety-Rehearsals on Each Shift C 185 SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0309 PLAN FOR EVACUATION (b) There shall be rehearsals of the fire plan. quarterly on each shift in accordance with the requirement of the local Fire Prevention Code Enforcement Official. (c) Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, the shift, staff members present, and a short description of what the rehearsal involved. (f) This Rule shall apply to new and existing facilities. Fire Drill rehearsal document has been modified to include This Rule is not met as evidenced by: the time of the rehearsal and a Based on a review of documents, the only records available onsite did not list the time of the description of what the rehearsal. rehearsal involved.

Division of Health Service Regulation

STATEMENT OF DEFIGIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X5) DATE SURVEY COMPLETED					
		HAL065035	B. WING		08/17/2016				
NAME OF I	PROVIDER OR SUPPLIER	8YREET AD	DRESS, OITY, (STATE, ZIP CODE		\neg			
CEDAR	CEDAR COVE ASSISTED LIVING 4200 JASMINE COVE WAY WILMINGTON, NC 28412								
(X4) ID PREFIX TAG	EFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU GROSS-REFERENCED TO THE APPRO DEFICIENCY)	OTION SHOULD BE COMPLE O THE APPROPRIATE DATE				
C 185	Continued From pa	ge 5	C 185						
	Based on a review records available or of what the rehears	ew of documents, the only asite included no description al involved.		,					
C 189	Building Equipment	Maintained Safe, Operating	C 189						
	mechanical, and plu care home shall be operating condition. (k) This Rule shall facilities with the ex	d all fire safety, electrical, imbing equipment in an adult maintained in a safe and							
	emergency lights w Battery powered en	vation, battery powered ould not work when tested. nergancy lights that will not least 90 minutes could ents and staff. Its are located:		New batteries were placed the emergency lights locate near the Administrator's of and kitchen.	d				
	Assisted Living dini- Unilluminated exit sevacuation in an en- 3. Based on observare prevented from resist the passage of doors that do not observed the possibilione space can quie the remainder of the	vation, many corridor doors closing quickly and latching to of fire and smoke. Corridor ose completely and latch ity that a fire that begins in kly spread to the corridor and	,	A new bulb was placed in the exit sign in the AL dining ro					
Division of H STATE FOR	naith Service Regulation M		ERCO	F9PN21	If continuation sheet	6 of 9			

Division of Health Service Regulation					NEROVED	
SYATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		HAL065035	B. WING	***	08/1	7/2016
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
CEDAR	COVE ASSISTED LIVI		MINE COVE TON, NG 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL GROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE	(X8) COMPLETE DATE
C 189	Continued From pa	ge 6	C 189			
C 189	Findings include; a. The 20 minute fidoor did not close of activated by the fire b. The smoke barriroom did not close the fire alarm syste o. One of the smoke Care did not close of the fire alarm syste d. The doors to be would not close and e. The door to bed when closed and dienough to be resist and fire. f. The door to bedropening well enough passage of smoke g. The door to bed and open. h. The door to bed latch because the beause the beause the beause the beause the beause the control of the c	re rated door near the front completely and latch when alarm system. er doors near the Activity completely when activated by m. alarm for a completely when activated by m. are barrier doors in Special completely when activated by m. are some 101, 105 and 213 is latch. Froom 215 would not latch d not fit the opening well ant to the passage of smoke com 207 did not fit the h to be resistant to the	G 189	The corridor doors have bee repaired to ensure that each door closes completely and properly latches.		
	are not sealed with one-hour fire rated possibility that a fire	. Holes and penetrations that materials approved for use in construction present the that begins in one space can				
	Findings include: a. Cracks in the ce room,	her areas of the facility. iling of the main electrical		All holes and penetrations in one-hour fire rated wells an ceilings have been sealed w	d/or Ith	
				materials approved for use i one-hour rated construction		
	e. Damaged ceiling f. Hole in ceiling at					
Division of H	ealth Service Regulation			11.11.11.11.11.11.11.11.11.11.11.11.11.		

4200 JAS	(X2) MULTIPLE A BUILDING; () B. WING DRESS, CITY, ST MINE COVE V TON, NC 284 ID PREFIX TAG	TATE, ZIP CODE)N	/2016
STREET AD 4200 JAS WILMING ENT OF DEFICIENCIES ST BE PRECEDED BY FULL ENTIFYING INFORMATION)	DRESS, CITY, ST MINE COVE V TON, NC 284	PROVIDER'S PLAN OF CORRECTION SHOULD)N	
4200 JAS WILMING WILMING OF DEFICIENCIES OF BE PRECEDED BY FULL ENTIFYING INFORMATION)	MINE COVE V TON, NC 284 PREFIX	PROVIDER'S PLAN OF CORRECTION SHOULD)N	
WILMING ENT OF DEFICIENCIES BY BE PRECEDED BY FULL ENTIFYING INFORMATION)	TON, NC 284	PROVIDER'S PLAN OF CORRECTION SHOULD	DBE	- AVE
THE PRECEDED BY FULL ENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL)	DBE	2000
,		DEFICIENCY) ·	RIATE	COMPLETE DATE
of the electrical room nel is located, ns were missing or not g to maintain the fire ing locations; Living room and Dining ng room (2),	C 189			-
SICAL PLANT OTHER of this Paragraph shall be rentilation at the rate of the per square foot. This poly to facilities licensed in natural ventilation in the rooms; ets; and ly to new and existing tion of Paragraph (e) existing facilities. I evidenced by: In there was no exhaust rhousekeeping closet. In the exhaust fans ing in the bathrooms off	C 199	in mop closet. Exhaust fans have been replaced in the bathrooms of		
Side to the State of the State	g to maintain the fire ng locations; Living room and Dining g room (2), BICAL PLANT OTHER this Paragraph shall be antilation at the rate of e per square foot. This oply to facilities licensed in natural ventilation in t rooms; ts; and y to new and existing ion of Paragraph (e) existing facilities. evidenced by: n, there was no exhaust housekeeping closet. In, the exhaust fans ing in the bathrooms off	g to maintain the fire ng locations; Living room and Dining g room (2), C 199 BICAL PLANT OTHER this Paragraph shall be antilation at the rate of e per square foot. This oply to facilities licensed in natural ventilation in t rooms; ts; and y to new and existing ion of Paragraph (e) existing facilities. evidenced by: n, there was no exhaust housekeeping closet. In, the exhaust fans ing in the bathrooms off	g to maintain the fire no locations; Living room and Dining g room (2), C 199 SICAL PLANT OTHER this Paragraph shall be antilation at the rate of e per square foot. This poly to facilities licansed in natural ventilation in t rooms; ts; and y to new and existing on of Paragraph (e) existing facilities. evidenced by: n, there was no exhaust housekeeping closet. Exhaust fan has been installed in mop closet. Exhaust fans have been replaced in the bathrooms of	g to maintain the fire no locations; Living room and Dining g room (2), C 199 SICAL PLANT OTHER this Paragraph shall be antilation at the rate of e per square foot. This poly to facilities licansed in natural ventilation in t rooms; ts; and y to new and existing on of Paragraph (e) existing facilities. evidenced by: n, there was no exhaust rhousekeeping closet. p, the exhaust fans no in the bathrooms off Exhaust fans have been replaced in the bathrooms off

STATEMENT OF DEFICIENCIES (X1) PROVIDER/GUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/GUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING: 01		(X3) DATE SURVEY COMPLETED			
	1	HAL065035	B. WING					
NAME OF	PROVIDER OR SUPPLIER		<u> </u>		08/17/201	16		
	4200 LABMINE COVE WAY							
CEDAR	GEDAR COVE ASSISTED LIVING WILMINGTON, NC 28412							
(X4) 10 PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENYIFYING INFORMATION)	ID PROVIDER'S PLAN OF GORRECTION (X5) PREPIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG CROSS-REPERENCED TO THE APPROPRIATE DATE DEFICIENCY)					
				DEFICIENCY				
Division of H	ealth Service Regulation							